IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 30, 2012

Kathy Quesnell, Administrator
Preferred Community Homes - Cougar Creek
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Cougar Creek, Provider #13G037

Dear Ms. Quesnell:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Cougar Creek, which was conducted on January 25, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 12, 2012,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by February 12, 2012. If a request for informal dispute resolution is received after February 12, 2012, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Michael A Case, LSW

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G037	A. BUILDING _____ B. WING _____	01/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Leader Trish O'Hara, RN Common abbreviations/symbols used in this report are: AKA - Also known as AQMRP - Assistant Qualified Mental Retardation Professional IED - Intermittent Explosive Disorder LPN - Licensed Practical Nurse NOS - Not Otherwise Specified OCD - Obsessive Compulsive Disorder PCLP - Person Centered Lifestyle Plan RN - Registered Nurse	W 000	Preparation and implementation of this plan of corrections does not constitute admission or agreement by Cougar Creek with the facts, findings, or other statements as alleged by the State agency dated January 25, 2012. Submission of this plan of correction is required by law and does not evidence the truth of any of the findings as stated by the survey agency. Cougar Creek specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 1 of 3 individuals (Individual #1) whose PCLPs were reviewed. This resulted in a	W 124	**W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS** All written informed consents will be reviewed and revised for all individuals to ensure they contain accurate information in accordance with their medication reduction plans. All written informed consents will be reviewed by the IDT at quarterly core team meeting to ensure they are updated and contain accurate information. Completion Date: March 31, 2012 Persons Responsible: AQIDP and Program Director	

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

2-13-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 lack of information being provided to an individual's guardian regarding psychiatric drugs. The findings include: 1. Individual #1's 1/17/11 PCLP stated he was a 58 year old male whose diagnoses included moderate mental retardation, major depressive disorder, IED, OCD, and seizure disorder. His Physician's Order, signed by the physician 11/23/11, stated he received Zyprexa (an antipsychotic drug) 5 mg daily, and fluoxetine (AKA Prozac - an antidepressant drug) 40 mg daily. Individual #1's written informed consents did not contain accurate information as follows: a. Individual #1's written informed consent for Zyprexa, dated 6/26/11, stated the drug was for agitation and aggression. However, his Medication Reduction Plan, dated 11/11/11, stated Zyprexa was for OCD exhibited by refusals and uncooperative behaviors. b. Individual #1's written informed consent for Prozac, dated 6/26/11, stated the drug was for agitation and aggression. However, his Medication Reduction Plan, dated 11/11/11, stated Prozac was for OCD exhibited by repetitive behaviors and fixating on certain items or events. During an interview on 1/25/11 from 2:10 - 3:25 p.m., the AQMRP stated both drugs were for signs and symptoms of OCD as indicated on the Medication Reduction Plan. The AQMRP stated Individual #1's written informed consents were inaccurate and needed to be revised.	W 124		

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W 124	Continued From page 2 The facility failed to ensure Individual #1's written informed consents contained accurate information.	W 124		
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to obtain special studies as recommended for 2 of 2 Individuals (Individuals #1 and #2) who received anticonvulsant drugs. This resulted in Individuals not receiving bone density screenings as recommended or in accordance with their needs. The findings include: 1. The National Center for Biotechnology Information (www.ncbi.nlm.nih.gov) published two articles summarizing bone density studies on individuals receiving long term antiepileptic drug therapy. One article, published in 2009 by the American Epilepsy Society, stated "Antiepileptic drug (AED) therapy for epilepsy is associated with metabolic bone disease and high risk for fractures. Reduced bone mineral density (BMD) has been reported in 20 to 75 percent of patients taking AEDs in cross-sectional studies." The article stated 3 to 5 years of AED therapy was a reasonable interval before assessing BMD. a. Individual #1's 1/17/11 PCLP stated he was a 58 year old male whose diagnoses included	W 326	**W 326 483.460(a)(3)(iii) PHYSICIAN SERVICES** The house LPN will consult with Individual #1 and Individual #3's primary care physicians regarding obtaining a bone density screening study. If the individual's primary care physician orders a bone density study, the house LPN will ensure it is completed in a timely fashion. All individuals who reside in the facility and receive anti-convulsant medications have the potential to be affected by this deficient practice. The facility will review the records of potentially affected individuals to determine if and/or when a bone density screening has been done. If a potentially affected individual has not had a bone density study and has been taking AEDs for 3 to 5 years, the house LPN will consult with the individual's primary care physician to obtain an order for a study or further guidance/instruction, in a timely fashion. The house LPNs will review each potentially affected individual's medical record to determine the use of AEDs, and the presence of a previous bone density study. PCH nursing will ensure that if an individual meets the criteria of 3 to 5 years of AED use and has not had a bone density study, the house LPN will consult with the individual's primary	

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W 326	Continued From page 3 moderate mental retardation, major depressive disorder, IED, OCD, and seizure disorder. His Physician's Order, signed by the physician 11/23/11, stated he received Topamax (an anticonvulsant drug) 600 mg daily and Depakote (an anticonvulsant drug) 1000 mg daily. Individual #1's Annual Nursing Summary, dated 1/25/11, stated Topamax had been started 1/13/04 and Depakote had been started 2/8/04. Topamax was discontinued in 2004, but restarted 3/31/06. However, Individual #1's record did not include information that a bone density screening had been completed or discussed. b. Individual #2's 8/15/11 PCLP stated he was a 33 year old male whose diagnoses included moderate mental retardation, IED, schizoaffective disorder, OCD, and psychosis NOS. His Physician's Order, signed by the physician 11/29/11, stated he received Depakote (an anticonvulsant drug) 1750 mg daily. Individual #2's record included a neurological exam, dated 5/10/04, which stated he was taking Depakote at that time. However, Individual #2's record did not include information that a bone density screening had been completed or discussed. During an interview on 1/25/12 from 2:10 - 3:25 p.m., two LPNs both stated they were unaware of any information addressing bone density screenings for either Individual #1 or Individual #2.	W 326	care physician for further guidance/instruction which may include a physician's order to obtain a bone density study. The house LPN will act upon the physician's orders/guidance/instruction, in a timely fashion. The RN will review all charts on a quarterly basis. One component of the review will include monitoring for the use of AEDs and if noted, the RN will review the record for a previous bone density study. If the individual has met the criteria of 3 to 5 years of AED use and has not had a previous bone density screening, the RN will work with the house LPN and the individual's primary care physician to obtain further instruction/guidance or an order to obtain a bone density screening. The RN will ensure that all physician orders are followed in a timely fashion. Completion date: March 20, 2012	

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W 326	Continued From page 4 The facility failed to ensure Individual #1 and Individual #2 received special studies for bone density screening in accordance with their needs.	W 326		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that nursing reviews had been completed on a quarterly basis for 3 of 3 Individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in the potential for medical problems to be identified in a timely fashion. The findings include: 1. Individual #1 - #3's records were reviewed and documented the following: a. Individual #1's 1/17/11 PCLP stated he was a 58 year old male whose diagnoses included moderate mental retardation, major depressive disorder, IED, OCD, and seizure disorder. He was admitted to the facility 7/19/90. Individual #1's record documented a quarterly nursing review was completed 11/18/11. However, there was no documentation quarterly nursing reviews had been completed for the first, second, or third quarters (January - September) of 2011.	W 336	**W 336 483.460(c)(3)(iii) NURSING SERVICES** The LPN previously responsible for nursing services at Cougar Creek is no longer employed by the facility. The new LPN responsible for nursing services at Cougar Creek, as of 11/8/11, completed individual #1, #2, and #3's quarterly assessments on 11/18/11. The house LPN has 2012 quarterly assessments at Cougar Creek scheduled in February, May, August and November to ensure quarterly assessments are completed as per the regulation. All individuals residing in the facility have the potential to be affected by this deficient practice. All nurses in the facility were in-serviced regarding the regulation pertaining to conducting nursing quarterly assessments on 2/8/12.The house LPN will review each individual's chart and establish when quarterly assessments were last completed. Each house LPN will develop a schedule for quarterly assessments ensuring regulatory compliance. The house LPN will provide this schedule to the RN. The RN will review client charts on a quarterly basis. One component of the review will include monitoring of quarterly assessment data and determining if quarterly assessments are	

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W 336	Continued From page 5 b. Individual #2's 8/15/11 PCLP stated he was a 33 year old male whose diagnoses included moderate mental retardation, IED, schizoaffective disorder, OCD, and psychosis NOS. He was admitted to the facility 10/20/08. Individual #2's record documented quarterly nursing reviews were completed 11/18/11, 8/15/11, and 5/10/11. However, there was no documentation a quarterly nursing review had been completed for the first quarter (January, February, March) of 2011. c. Individual #3's 11/29/11 PCLP stated he was a 21 year old male whose diagnoses included mild mental retardation, Asperger's disorder, mood disorder NOS, and seasonal affective disorder. He was admitted to the facility 3/24/04. Individual #3's record documented quarterly nursing reviews were completed 11/18/11, 5/10/11, and 1/20/11. However, there was no documentation a quarterly nursing review had been completed for the third quarter (July, August, September) of 2011. During an interview on 1/25/12 from 2:10 - 3:25 p.m., the facility's LPN and Administrator both stated the former LPN (who left in November 2011) had failed to complete nursing quarterlies as required. A second LPN, who was present during the interview, stated the facility RN did address the issue, but the former nurse failed to follow through. The facility failed to ensure nursing reviews had been completed on a quarterly basis.	W 336	completed as per the regulatory requirement. The RN will also refer to the LPNs pre-established schedule of quarterly assessments to assist each nurse with maintaining regulatory compliance and ensuring quarterly assessments are complete, accurate, and filed in the record in a timely fashion. Completion Date = March 20, 2012	

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W 383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure only authorized persons had access to the key to the drug storage area for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for unauthorized persons to access individuals' drugs. The findings include: 1. During observations at the facility on 1/23/12 from 3:00 - 4:00 p.m. and from 4:35 - 6:30 p.m., and on 1/24/12 from 8:00 - 9:05 a.m. and from 1:50 - 2:45 p.m., a lanyard with a key ring was noted to be hanging on the outside of the closet door in the dining area. During the observations, staff were noted to obtain the keys, open various cabinets in the facility including the closet on which the keys hung, and were noted to use the keys to access the medication cabinets during the observation on 1/24/12. The keys were then returned to the closet door handle. During both observations on 1/23/12, work crews were noted in the facility remodeling one of the bathrooms. Also, during an observation on 1/25/12 from 1:50 - 2:45 p.m., Individual #3's counselor was noted to be at the facility in the dining area. When asked during an observation, on 1/24/12 from 8:00 - 9:05 a.m., a staff stated the keys were	W 383	**W 383 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING** The house LPN and administrator held an in-service with all staff on 2/1/12. A portion of the in-service included the regulatory requirement of ensuring only authorized persons have access to the key for the drug storage area. All individuals residing in the facility have the potential to be affected by this deficient practice. The house LPN will conduct random weekly observations in each of his or her group homes; the observation will specifically target the security of the medication key as well as ensuring the medication cabinet is locked. If the key is found to be unattended or in the possession of an unauthorized individual, the LPN will immediately ensure the security of the medication key. The LPN will also notify the house administrator and will work with as a team in determining if additional training or disciplinary action is necessary. If the medication cabinet is found to be unlocked, the LPN will follow the same procedure of securing the medication cabinet immediately, and notifying the administrator. The random observations will be documented on a checklist with the date, time, house, location of the medication key, security of the medication cabinet, name of the	

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W 383	Continued From page 7 used by all staff to unlock all cabinets in the facility. During the same observation, a second staff stated the keys were kept either on the outside of the closet door, hanging on the back of a chair in the dining area, or with the staff who was passing medications. When hanging on the outside of the closet or on the back of a dining chair, the keys which opened the medication cabinet were accessible to anyone present in the facility, including individuals residing at the facility, parents, repair personnel, visitors, etc. During an interview on 1/25/12 from 2:10 - 3:25 p.m., the Administrator and two LPNs all stated the medication certified staff present should have kept the keys in their possession, and should not have left the keys hanging where they were accessible to others. The facility failed to ensure only authorize persons had access to the keys to the medication storage area.	W 383	medication assistant, and the corrective action taken , if applicable. The RN will review the checklist data on a monthly basis and will ensure appropriate corrective action has occurred, if applicable. Completion Date = March 20, 2012	

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Bureau of Facility Standards

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MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	**MM164 16.03.11.075.04 DEVELOPMENT OF PLAN OF CARE** Please refer to the plan of correction for W124. RECEIVED FEB 13 2012 FACILITY STANDARDS	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. During an environmental review on 1/24/12 from 1:50 - 2:30 p.m., the following was noted: - There was a 2 inch circular section of plaster missing above the light switch to the left of the	MM380	**MM380 16.03.11.120.03(a) BUILDING AND EQUIPMENT** The 2 inch circular section of plaster that was missing above the light switch to the left of the back door will be repaired. As will the 1 inch indentations in the wall to the right of the dining room table. The baseboard in Individual #1's bedroom will be replaced. The 4 foot section of trim board approximately 1.5 foot off the ground on the southwest corner of the building exterior will be replaced/repaired. On the back of the building exterior, the 5 foot section of siding above the foundation will also be replaced. Completion date: 2-29-12 Person completing: Maintenance	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — 2-13-12 (X6) DATE

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 1 back door. - There were three 1 inch indentations in the wall to the right of the dining table. - The baseboard in Individual #1's bedroom was missing from approximately three-quarters of the room. - On the southwest corner of the building exterior, there was a 4 foot section of trim board approximately 1.5 foot off the ground which was rotting and falling apart, exposing the insulation board behind. - On the back of the building exterior, there was a 5 foot section of siding above the foundation that was rotting and falling apart. - The side door of the 15 passenger facility van had a hole in the cover panel approximately 1.5 foot in diameter, and the interior handle was not functional. The facility failed to ensure environmental repairs were maintained.	MM380	The side door of the 15 passenger door van will have the cover panel fixed and the interior handle will be repaired/replaced. Completion date: 5-12-12 Person Completing: Cougar Creek RSC	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W326.	MM735	**MM735 16.03.11.270.02 HEALTH SERVICES** Please refer to the plan of corrections for W326 and W336.	

PRINTED: 01/30/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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MM735	Continued From page 2	MM735		
MM766	16.03.11.270.03(c)(iii) Periodic Reevaluation The periodic reevaluation of the type, extent, and quality of services and programming; and This Rule is not met as evidenced by: Refer to W336.	MM766	**MM766 16.03.11.270.03(c)(iii) PERIODIC REEVALUATION** Please refer to the plan of corrections for W336.	